

Aggression against doctors: a review

F D Richard Hobbs FRCGP Ursula M Keane MRCGP

J R Soc Med 1996;89:69-72

Keywords: aggression; violence; Health and Safety Acts; training; counselling

SUMMARY

Although the number of doctors abused is comparatively small, the perceived risk of violence presents a major issue for the whole profession since the consequences extend to all doctors through the intimidation reports in the medical press and newspapers engender.

INTRODUCTION

The risk of violence to doctors in their working environment is not a new phenomenon^{1,2}, although occasional incidents highlight the seriousness of this risk as in the fatal stabbing at work of a Scottish general practitioner (GP) in 1994. Such devastating events are rare but doctors still perceive aggression towards them as increasing, in parallel to the increased prevalence of violence in society^{3,4}. The medical press, particularly GP newspapers have carried numerous reports of assaults on doctors⁵⁻⁷. Suffering or fearing aggression will adversely influence the attitudes of doctors to their work⁸⁻¹⁰.

The true incidence of aggression against doctors is difficult to determine from the literature. Although much has been written on the topic, it is often anecdotal and aimed at advising doctors on how to avoid or defuse such situations^{1,11-14}. Available incidence data suggest widespread variation in rates between doctors working in different areas and among different groups of patients. Such variation complicates extrapolation from the data. Other obstacles to determining overall incidence arise from the variation in the severity of incidents recorded by different studies, further compounded by the use of differing definitions of what constitutes violence.

The Health and Safety Executive define violence as 'any incident in which an employee is threatened or assaulted by a member of the public in circumstances arising out of the course of his/her employment'¹⁵. Such a broad definition will include many incidents which are not currently reported and which staff may even expect to encounter as part of their normal work¹⁶.

For doctors who employ staff (most GPs), the issue of risk of violence at work confers legal obligations. Under the *Health and Safety at Work Act* 1974¹⁷, employers have a duty to identify the nature and extent of any health risk and to devise measures to provide safe systems of working, safe

working environments, and information to staff. Every workplace should therefore have a policy on dealing with violence at work. Of all work settings, medical sites carry the greatest risk to staff of verbal abuse and threats, with 73% of staff on medical premises suffering abuse, compared to 65% on recreational premises and 63% for transport and public administration². One in 20 National Health Service (NHS) staff have been threatened with a weapon². Yet despite the risks of aggression and the legal obligations: only 43% of hospitals have a policy on violence; 3% of hospitals offer special staff training; 50% of hospitals give no training at all to staff; only 25% of hospitals advise staff on reporting procedures; and 87% of the health service staff are worried about violence in their work¹⁸.

SCALE OF AGGRESSION IN GENERAL PRACTICE

The largest study of aggression towards family doctors found that 63% of responders (1093 GPs in West Midlands) had experienced abuse or violence during the previous 12 months, while 18% experienced some sort of abuse at least once a month¹⁹. While 3% had sustained minor injuries from an assault in the previous 12 months, only 0.5% had suffered serious injury. A small 1991 survey of 120 inner city GPs found that 54% of doctors or their staff were involved in a major episode of violence in the previous few years²⁰. Risk varies on where a doctor works, with 87% of doctors in the inner city survey perceiving violence as increasing²⁰, in contrast with the larger, geographically diverse sample where only 14% thought aggression was increasing¹⁹.

A telephone survey of 150 GPs in 1995 found that 61% had ever been a victim of, or threatened with, violence during the course of their work and 45% said the fear of violence had affected their approach to their work²¹. Many GPs were reportedly anxious over home visits with some having abandoned doing their own night visits²¹. In a recent postal survey of 126 GPs in East London, 79% said they had experienced aggression during the past 12 months²². 60% felt that the level of violence towards doctors was

increasing²³. A London Community Health Council found that six out of 10 GPs are facing more aggression from patients²⁴.

The problem is not limited to major cities. In a survey of 170 GPs in Wales: 25% of respondents had been assaulted by patients who had punched them, used knives and thrown furniture; 50% reported verbal threats and abuse; 60% had cars broken into and 20% had vehicles stolen²⁵.

SCALE OF AGGRESSION IN HOSPITALS

Aggression towards doctors is not restricted to GPs, although they are the group for whom there are the most recent data. In the UK, the clinical areas most associated with violent events are accident and emergency (A&E) departments, community settings and psychiatry². This contrasts with experience in the States where assaults are commonest in psychiatric hospitals, followed by accident and emergency departments and intensive care units²⁶.

A 1992 study of violent incidents in a large UK A&E department found 283 episodes recorded in a violent incidents record over 12 years¹⁶. 36% of incidents involved violence towards staff, but information was recorded in a haphazard manner and many incidents had not been listed. Junior doctors in A&E medicine, psychiatry and general practice recorded, during a seminar on violence, that 41% had experienced physical violence, with 36% receiving injuries²⁷ (cf GP data of 3%). One in 11 junior doctors needed time off work as a result of injury. Verbal abuse was even more common with 64% of junior doctors sometimes or often experiencing it. A 1995 BMA survey of 250 hospital doctors found that 55% had been victims of, or threatened with, violence at work and 27% still felt affected²⁸. 74% would support legislation requiring hospitals to maintain prescribed standards of security and ensure staff receive regularly updated security training. Presumably they were unaware that hospitals already have this obligation.

Under-reporting of violent incidents, both physical and verbal is widespread^{14,16,29}. Explanations vary, but individuals will have different perceptions of what constitutes aggressive behaviour. Other factors include lack of time, reluctance to fill in forms, and fear of being blamed for incidents^{16,20,29}. Doctors have reported coping with aggression as 'part of the job' and some feel too guilty or embarrassed to report events^{16,20,30}. The true incidence of violence may therefore be far higher than the range of 54% to 79% found in the studies above. Recent surveys indicate an increase in the rates of aggression both in hospital and in the community.

CHARACTERISTICS OF AGGRESSORS AND THE PRECIPITANTS OF VIOLENCE

Factors reported as being related to, or causative of, violence vary. Frequently cited patient factors include male sex,

relative youth, and the effects of alcohol or drug consumption. In the large GP study, the usual instigators of aggression were men (66% of all cases, rising to 76% in cases involving assaults or injury), and the aggressor was under 40 in 76% of cases¹⁹. There was no difference in prevalence between the 15–29 and 30–39 age bands, contrary to the common view that it is predominantly the young who engage in aggression. A preponderance of male aggressors was also noted in the Bristol study of violent incidents in A&E (17 men to 3 women)¹⁶. The age range implicated in that study (17–30) was younger. Violence among psychiatric inpatients also involves men in the age range of 15–40³¹.

Interestingly, in one A&E study companions were more often involved in the violent incidents than patients themselves¹⁶. Companions were also implicated in aggression in general practice, with 38% of aggressors being relatives or friends of the patients¹⁹. Time of day has also been cited as an associated factor, with the hours between 18:00 h and 07:00 h considered the worst^{10,27}.

Drugs and alcohol are frequently cited causes of violence³², and were involved in 65% of violent cases in one A&E¹⁶ and were the most frequent precipitants in general practice (27% of all cases)¹⁹. Intoxication is the major factor, alongside mental illness, in serious incidents involving assaults or injury¹⁹. Other contributory factors include the frustration associated with lengthy waiting times, quoted as a factor in A&E¹⁶ and general practice^{19,20}. Where prolonged waiting time was quoted as a factor, incidents can start with receptionists, although 73% of doctors became involved²⁰. Prolonged waits are also associated with vandalism on surgery premises.

A recurring theme in reports of aggression towards doctors is the link between violence and mental illness^{1,16,19,20}, with mental illness being the most important factor implicated in serious incidents involving assault or injury in general practice (38% of such incidents)¹⁹. Patient anxiety was the most quoted precipitant of verbal abuse and second commonest cause of verbal abuse with threats¹⁹. A recent bereavement was reported in 5% of events¹⁹.

CONSEQUENCES OF AGGRESSION

The possible effects of aggression on an individual are varied and likely to depend on the severity and frequency of episodes and the perceived vulnerability to further episodes. In general practice, one study estimated the threat of violence at 1 in 500 consultations³³, while in another study 16% of GPs reported monthly verbal abuse and 1% daily verbal abuse¹⁹. Among hospital doctors up to 55% have experienced aggression during the course of their work²⁸. The health implications of violent events can be considerable

and include post traumatic stress disorder²⁷. It is more difficult to quantify the emotional distress caused by verbal violence such as abuse, threats, innuendoes or racial harassment. However, varied symptoms including stress, insomnia, agoraphobia and depression have been reported following such incidents at work³⁴. Other adverse effects include: long term sick leave, poor staff morale and higher than necessary staff turnover²⁷. The most effective way of minimising the psychological effects following a violent incident is to follow an early debriefing model employing counsellors with specialist skills³⁵. Early counselling has also been shown to reduce the amount of subsequent sick leave⁸.

It is even more difficult to determine the continuing effects of the fear of violence on doctors. Nearly 75% previously abused GPs do, at times, express ongoing fears for their safety at work¹⁰. Fear was most commonly reported during visits made out of hours, with mild fear being occasionally experienced by 56% of GPs between 19:00 h and 23:00 h and by 51% after 23:00 h¹⁰. Twenty-one per cent of abused GPs continued to be frequently severely fearful on evening visits and 31% were always fearful¹⁰. Women were significantly more likely to report fear and at significantly higher levels¹⁰. A small survey found 70% of women GPs in Birmingham had fears for their personal security while doing night visits (personal correspondence).

Experiencing aggression from patients can lead to a change in behaviour. Coping strategies among GPs include increasing prescribing, referring threatening patients to secondary care services and taking threatening patients off their lists^{9,20}. Hobbs found that 73% of doctors made no changes to practice because of fears over aggression, but 27% listed 68 different types of change to practice including striking off more patients (12%), discussing the problem at practice meetings (11%), installing panic buttons (9%) and increasing the use of deputizing service (7%)⁹. A survey of GPs in East London reported that 57% had changed their practice as a result of violence²³. Among hospital doctors 27% reported that their approach to work was changed due to violence or the fear of violence, although the nature of this change was not specified²⁸. A worrying 30% of respondents in one survey of GPs indicated they would not do general practice and/or medicine again²⁰. However, this extreme negative reaction was not substantiated in a larger survey where 7% of those surveyed felt less committed to medicine, 4% less confident and only 0.2% thinking of giving up practice because of fears of aggression¹⁰.

Most of the changes arising as a result of aggression, or the fear of aggression, have cost implications to the NHS and may also lead to a deterioration in the quality of the doctor-patient relationship. Indeed, GPs in South Wales have struck off 300 patients in the past year for being violent or abusive³⁶. The climate of fear among GPs may have

recruitment implications, particularly in inner city areas where the problem is perceived to be more pervasive.

RAMIFICATIONS FOR THE NHS

In April 1994 the Department of Health, in response to doctors' concerns, amended GPs' terms of service to allow the immediate removal of a patient from a GPs list following an act of actual or threatened violence. The British Medical Association have subsequently circulated guidance on combating violence in general practice, stating that:

To tolerate abusive or violent behaviour invites the perpetrator to repeat his or her actions. Therefore, the prevention of violent and threatening behaviour is vital to our professionalism¹².

The guidance covers preventative measures and recommended action following a threatening or violent incident, and offers advice on the protection afforded to doctors under criminal and civil law. It concludes that: 'This guidance may seem to be contrary to our duty to provide care and uphold patient confidentiality. Sadly, the need for it has been caused by social and cultural changes beyond our influence or control. Indeed, if we fail to use the law to uphold the doctor-patient relationship, we may find that its value inexorably declines.'

A major priority now is the provision of training for doctors on the avoidance and management of potentially aggressive situations. Training should encompass awareness of warning signals, such as the body language that can precede an aggressive outburst. Communication skills training can help to teach doctors and other staff how to defuse such situations and how to control their own emotions so as not to meet anger with anger. Early intervention to address patients' grievances is encouraged, but advice on how long to persist with this approach before calling for assistance is also important. Several training packages are being developed³⁷.

Once a violent incident has occurred, whether in hospital or general practice, a crisis plan should be implemented. This should form part of a protocol for dealing with aggression and include incidents involving all staff members. A full record should be taken of the incident and relevant authorities (including the police) informed. Staff members involved in any incident should, where desired, be offered counselling³⁸. Adopting a training package and developing a protocol for each workplace is a requirement under the *Health and Safety at Work Act*, but should also improve confidence and help to reduce the occurrence of incidents.

In addition to training there are a number of practical considerations that may help to reduce violent incidents, such as reducing lengthy waiting times. In general practice this could be addressed by auditing the appointment system with a view to increasing the consulting interval in cases

where doctors consistently run late, and/or increasing the number of available appointments. Patients should be kept informed of likely waits and explanations provided. In A&E departments the number and skill mix of staff on duty at key times could be reviewed. Since patients under the influence of drugs or alcohol may pose a threat, policies should exist to deal with them more quickly (with some mechanism to follow up this disruption with the patient on a later, less charged, occasion). Restricting the number of patient companions may be particularly helpful in busy A&E departments.

NHS investment in safer working environments is also needed. Adequate resources to meet desirable design features need to be identified, especially at a time when the recruitment of doctors in hospital and general practice is becoming problematic. Security measures such as unconcealed closed circuit television with 24-h video recording may act as a deterrent to vandalism of property and is also helpful for providing evidence afterwards, particularly in criminal cases. The presence of security staff in the NHS may also act as a deterrent and increase staff confidence. Indeed, it is difficult to see how practitioners can continue to provide certain services in isolation much longer. GPs are perhaps the only core service that continue to visit people in their own homes, at whatever hour, and on their own.

CONCLUSIONS

The risk of suffering violent injury as a doctor remains low. However, the scale of doctors' fears for their personal safety deserves the implementation of explicit strategies by the NHS. The most immediate requirements are the development and provision of more training opportunities for doctors and their staff, more post-event counselling becoming available and greater NHS investment in safer workplaces. Longer term implications may threaten the provision of certain core services, such as A&E and out of hours general practice, unless safer working practices become available. The general public should understand the risks and enter the debate.

REFERENCES

- 1 Anonymous. Assaults on doctors. *BMJ* 1978;**6122**:1229-30
- 2 Health Services Advisory Committee. *Violence To Staff In the Health Services*. Health and Safety Commission, London: HMSO, 1987
- 3 Home Office. *Criminal Statistics in England and Wales*. London: HMSO, 1995
- 4 Home Office. *Police Crime Statistics (1970-1988)*. London: HMSO, 1989
- 5 Anonymous. Threat to family frightens GP off. *Gen Practit* 1994;June 24
- 6 Anonymous. Two GPs are attacked in practice. *Gen Practit* 1994;November 25:1
- 7 Anonymous. GP sees justice done to attackers. *Gen Practit* 1995;February 10:1
- 8 Schnieden V, Maguire J. *A Report on Violence at Work and its Impact on the Medical Profession Within Hospitals and the Community*. London: BMA, September 1993
- 9 Hobbs FDR. General practitioners' changes to practice due to aggression at work. *Fam Pract* 1994;**11**:75-9
- 10 Hobbs FDR. Fear of aggression at work among general practitioners who have suffered a previous episode of aggression. *Br J Gen Pract* 1994;**44**:390-4
- 11 Health and Safety Executive. *Violence To Staff*. London: HMSO, 1993
- 12 General Medical Services Committee. *Combating Violence In General Practice*. London: BMA, 1994
- 13 Hobbs R. Violence and safety. *Practitioner* 1990;**234**:979-82
- 14 Schnieden V. Violence at work. *Arch Emerg Med* 1993;**10**:79-85
- 15 Health and Safety Executive. *Violence To Staff*. London: HMSO, 1986
- 16 Cembrowicz SP, Shepherd JS. Violence in the accident and emergency department. *Med Sci Law* 1992;**32**:118-22
- 17 *A guide to the Health and Safety at Work Act*. London: HMSO, 1974
- 18 National Union of Public Employees. Violence in the NHS. *Hlth Serv News* 1991;April 4
- 19 Hobbs FDR. Violence in general practice: a survey of general practitioners' views. *BMJ* 1991;**302**:329-32
- 20 Myerson S. Violence to general practitioners and fear of violence. *Fam Pract* 1991;**8**:145-7
- 21 Anonymous. GPs are haunted by the spectre of violence. *BMA News Rev* 1995;January
- 22 Anonymous. GP violence blackspot. *Pulse* 1995;January 28:4
- 23 Anonymous. Aggression against GPs hits record levels. *Gen Practit* 1995;January 27:1
- 24 Anonymous. GPs face increased aggression. *Gen Practit* 1995;February 24
- 25 Anonymous. Quarter of GPs assaulted as surgery violence soars. *Pulse* 1994;December 17/31
- 26 Drummond DJ, Sparr LE, Gordon GH. Hospital violence reduction among high risk patients. *JAMA* 1989;**261**:2531-4
- 27 Schnieden V. Violence against doctors. *Br J Hosp Med* 1993;**50**:6-9
- 28 Anonymous. Doctors demand training in dealing with attackers. *BMA News Rev* 1995;January
- 29 Lion JR, Snyder W, Merrill GL. Under reporting of assaults on staff in a state hospital. *Hosp Commun Psychiat* 1981;**32**:497-8
- 30 D'Urso P, Hobbs FDR. Aggression and the general practitioner. *BMJ* 1989;**298**:97-8
- 31 Fottrell E. A study of violent behaviour among patients in psychiatric hospitals. *Br J Psychiat* 1980;**1**:216-221
- 32 Anonymous. Alcohol and violence. *Lancet* 1990;**336**:1223-4
- 33 Neville RG. Violent patients in general practice. *Practitioner* 1986;**230**:1105-8
- 34 Income Data Services Study. *Violence Against Staff*. London: Income Data Services, 1990
- 35 Caldwell MF. Incident of PTSD amongst staff victims of patient violence. *Hosp Commun Psychiat* 1992;**43**:838-9
- 36 Anonymous. 300 abusive patients struck off. *Gen Practit* 1994;June 17:4
- 37 Harris A, Wykes T, Hobbs FDR, Brisby T. *Prevention and management of violence in general practice: a training course manual*. London: Churchill Livingstone, 1995
- 38 Wykes T, Mezey G. Counselling for victims of violence. In: Wykes T, ed. *Violence and Healthcare Professionals*. London: Chapman & Hall, 1994

(Accepted 3 May 1995)